Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>			(X3) DATE SURVEY COMPLETED	
				A. BOILDING.				
FCL011319		B. WING		11/0	11/06/2014			
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
SERENIT	TY HEART FAMILY CA	ARE HOME # 234		NTRY TIME ( ER, NC 2874				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 000 Initial Comments			C 000					
	Report by Glenn Ho	oppin						
DHSR Construction Section conducted a Biennial Survey on November 06, 2014 at the above referenced facility. DHSR records indicate the home was first licensed on July 24, 1997 as a Family Care Home for six Residents with no more than three who are non-ambulatory (un-able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 1992 "Rules for Family Care Homes Minimum and Desired Standards and Regulations", the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, and the 1996 (97 rev) North Carolina State Building Code - Section 419.3 - Small Residential Care Facilities.								
		risit, we cited deficier ble plan of correctior						
C 174 Building Equipment Maintained Safe, Operating		C 174						
	EQUIPMENT (a) The building a mechanical, and pl care home shall be operating condition	nd all fire safety, electumbing equipment in a maintained in a safet.  apply to new and ex	ctrical, n a family e and					
		et as evidenced by: of cover on the rear	outside					

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
		FCL011319	B. WING		11/0	6/2014
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  234 COUNTRY TIME CIRCLE  LEICESTER, NC 28748						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 174	GFCI receptacle is proof cover. Provide orders and any other concerning the repart Section.  2. The client bathrowork. Hire a qualifit replace the ventilating any receipts, invoic supporting docume to the DHSR Constant of the DHSR Constant of the provide photos and other supporting docume to the DHSR.  4. There are multiple deck. Cease smoked provide proper cigar receptacles in the carea. Provide photos and provide proper cigar receptacles in the carea. Provide photos	missing. Replace the weather le photos and receipts, work er supporting documentation air to the DHSR Construction  oms ventilation fans do not ed contractor to repair or on fans. Provide copies of es, work orders or any other ntation concerning the repair ruction section.  ctor in the staff quarters is ed. Have a qualified individual e damaged smoke detector. The receipts, work orders and any ocumentation concerning the Construction Section.  de cigarette burns on the rear ing on the rear deck and	C 174			
C 142	8. Outside Entrand .2209) c. At least two outsidents 'floor lev accessible by ramp inches of length of entrances/exits, the	exits-Ramps  Inment (10 NCAC 42C .2201)  Inside entrances/exits for the real must be ground level or with a 1 inch rise for each 12 the ramp. If there are only two the entrances/exits must be as other as reasonably possible.	C 142			

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
FCL011319		B. WING		11/06/2014			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SERENIT	SERENITY HEART FAMILY CARE HOME # 234  234 COUNTRY TIME CIRCLE LEICESTER, NC 28748						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 142	(The requirement for ground level applie one resident who ne getting up or down)  This Rule is not mean the front entrance ramp. The facility is ambulatory resident required at the front permits and hire and construct a handicate requirements of the photos and copies invoices, and any of the DHSR Const.	or the ramp at exits not at so to homes which have at least eeds personal assistance in steps.)  Let as evidenced by: to the facility does not have a so licensed for up to three non tts, therefore a ramp is to entrance. Obtain all required equalified contractor to ap ramp that meets the efamily care rules. Provide of all permits, approvals, ther supporting documentation ruction section.	C 142				
C 145	C 145  Outside Entances/Exits-Handrails  IV. The Building C. Physical Environment (10 NCAC 42C .2201) 8. Outside Entrances/Exits (10 NCAC 42C .2209) f. All steps, porches, stoops and ramps must be provided with handrails and guardrails.  This Rule is not met as evidenced by: The front porch has a large area that is unprotected by handrails. Hire a qualified contractor and obtain all required permits and install hand rails on the open area of the front porch and the handicap ramp. Provide photos and copies of all permits and approvals and all other supporting documentation to the DHSR Construction section.		C 145				

Division of Health Service Regulation

STATE FORM 6899 VUNU21 If continuation sheet 3 of 4 Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CLIA BER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b> (X3) DATE SURV  COMPLETE				
		FCL011319		B. WING		11/0	6/2014
NAME OF PROVIDER OR SUPPLIER  SERENITY HEART FAMILY CARE HOME # 234  LEICESTER, NC 28748							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE

6899

Division of Health Service Regulation STATE FORM